PRINTED: 08/13/2009 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		297126	B. WIN	IG	<del></del>	05/0	6/2009	
	OVIDER OR SUPPLIER			2	REET ADDRESS, CITY, STATE, ZIP CODE 1940 S JONES BLVD STE A LAS VEGAS, NV 89146			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
G 000	INITIAL COMMENT	S	G	000				
G 143	a result of the Medicunder 42 CFR Part 4 conducted at your a 5/6/09.  The active census of 78. Fifteen clinical rincluding three close were conducted.  The findings and comby the Health Division prohibiting any criminactions or other claim available to any part state, or local laws.  The following regular identified: 484.14(g) COORDINGERVICES  All personnel furnish to ensure that their effectively and support the plan of care.  This STANDARD is Based on interview agency failed to ensure their efford and supported the organism of the support	eficiencies was generated as care re-certification survey 484 - Home Health Services, gency from 4/30/09 through on the first day of survey was records were reviewed, ed records. Five home visits inclusions of any investigation on shall not be construed as inal or civil investigations, ms for relief that may be ty under applicable federal, attory deficiencies were investigation or the objectives outlined in the sure staff maintained liaison its were coordinated effectively objectives as outlined in the 15 patients (#1, 3, 15).	G	143				
	Findings include:							
LABORATORY	DIRECTOR'S OR PROVIDER	R/SUPPLIER REPRESENTATIVE'S SIGNATUR	E		TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		297126	B. WIN	IG	<del></del>	05/0	6/2009
	OVIDER OR SUPPLIER			2	REET ADDRESS, CITY, STATE, ZIP CODE 1940 S JONES BLVD STE A LAS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)		.D BE	(X5) COMPLETION DATE
G 143	joint pain, cardiac dys secondary to chronic  A Nursing Clinical No revealed Patient #1 h 40 and 58 beats per range AM and 8:45 AM.  A NCN, dated 4/2/09 heart rate of 54 BPM PM.  A NCN, dated 4/8/09 heart rate of 40 BPM BPM "after transferring between 12:00 PM and The NCN had an area corner for the staff to (medical doctor), SN (certified nursing assist therapy), OT (occupar (Masters prepared so services for Patient #15).	ted on 6/30/08 with muscle weakness, multiple srhythmias and anemia kidney disease.  Interpretation (NCN) dated 3/14/09, and a heart rate of between minute (BPM) between 8:00  Interpretation, revealed Patient #1 had a between 1:00 PM and 1:45  Interpretation, revealed Patient #1 had a while in bed and a rate of 50 ang (from bed to wheelchair) and 12:50 PM.  In the lower right hand indicate they spoke with MD (skilled nursing), CNA istant), PT (physical attional therapy), or MSW obcial worker) providing 1.  In the lower right hand indicate they spoke with MD (skilled nursing), CNA istant), PT (physical attional therapy), or MSW obcial worker) providing 1.  In the lower right hand indicate they spoke with MD (skilled nursing), CNA istant), PT (physical attional therapy), or MSW obcial worker) providing 1.  In the lower right hand indicate they spoke with MD (skilled nursing), CNA istant), PT (physical worker) providing 1.	G	143			
	. 20011110 1140 4411111						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		297126	B. WIN	IG		05/0	6/2009
	OVIDER OR SUPPLIER		,	2	REET ADDRESS, CITY, STATE, ZIP CODE 2940 S JONES BLVD STE A LAS VEGAS, NV 89146	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORI PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE A DEFICIENCY)		LD BE	(X5) COMPLETION DATE
G 143	obesity.  A Case Conference (documented Patient at the home telephone. registered nurse (RN) The note lacked signal assigned to the case documentation indical were aware of the telephone. Various attempts to construct MSW to drive home."  Patient #3's clinical recommunication Note page) dated 4/8/09, of the telephone. The communication of the telephone of the t	deep vein thrombosis, ipheral vascular disease and a ccc) note dated 3/23/09   #3 was having problems with The note was signed by the who admitted the patient. It atures of other disciplines are the other disciplines are the other disciplines are phone issue.  Becord contained a "Patient and signed by the Director of a (DPS) which read, "MSW are alworker) completed contact pt (patient) via phone. It is a by as pt is unable to leave a ccord contained a physician Orders (one on which the physical per (one on which the physical per (patient) is a 'no pick-up'. The properties of the physical per number) x (times) 5   3/30/09, 4/1/09, 4/5/09 and the form pt and/or family. The properties of th	G	143			
			1				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		297126	B. WING	<del></del>	05/0	05/06/2009	
	ROVIDER OR SUPPLIER		294	ET ADDRESS, CITY, STATE, ZIP CODE 10 S JONES BLVD STE A S VEGAS, NV 89146	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
G 144	muscle weakness an evacuation of subdur.  The clinical record for Communication Note 4/15/09, indicating the PT (physical thera 4/15/09 evaluation to increased sleepiness  On 4/20/09, the patie acute care facility see sleepiness and lethar lacked documented of (registered nurse) was tatus of Patient #15 484.14(g) COORDIN. SERVICES  The clinical record or conferences establish reporting, and coordin occur.  This STANDARD is a Based on interview, review, the agency faconferences establish reporting, and coordin reporting, and coordin review, the agency faconferences establish reporting, and coordin record for successive suc	diabetes mellitus, debility, destatus post craniotomy for all hematoma.  Patient #15 contained a //Physicians Order dated expatient's family had called apist) to reschedule the 4/17/09 due to the patient's and lethargy.  In twas transported to an condary to the increased gy. The clinical record evidence indicating the RN is notified of the changed on 4/15/09.  ATION OF PATIENT  minutes of case in that effective interchange, mation of patient care does in the conduction of patient care does in the care does in the conduction of patient care does in the conduction of patient care does in the care does in the conduction of patient care does in the care	G 144				

1 '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[` '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING				
		297126	B. WING		05/06/2009		
	VIDER OR SUPPLIER		2940	T ADDRESS, CITY, STATE, ZIP CODE S JONES BLVD STE A S VEGAS, NV 89146			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F C C C C C C C C C C C C C C C C C C C	oint pain, cardiac dyssecondary to chronic  The clinical record for undated Case Conferndicated the patient reproperty to evaluate and furpight tolerance/endicated the signature of the contained the signature. The contained the signature of the contained the signature of the contained the signature. The contained the signature. The contained the signature of the contained the signature of the contained the signature.  A CC form dated 4/23 needed PT for "difficulties affects of the patient was advised of the patient #3  Patient #3 was admitted diagnoses including of the patient #3	red on 6/30/08, with muscle weakness, multiple or hythmia and anemia kidney disease.  Patient #1 contained an ence (CC) form which needed physical therapy treat for " decreased urance and decreased divance and decreased of three nurses. There on the form. There was no expressed expressed of the services.  B/09 indicated Patient #1 culty in transfer, decreased urance, poor safety/balance, in lower back, difficulty with walker)." The 4/13/09 form re of one nurse. There was the was no documented ised of the patient's need for and difficulty with gait."  B/09 indicated Patient #1 culty in transfer, poor all and difficulty with gait."  B/09 indicated Patient #1 culty in transfer, poor all and difficulty with gait."  B/09 indicated Patient #1 culty in transfer, poor all and difficulty with gait."  B/09 indicated Patient #1 culty in transfer, poor all and difficulty with gait."  B/09 indicated Patient #1 culty in transfer, poor all and difficulty with gait."  B/09 indicated Patient #1 culty in transfer, poor all and difficulty with gait."  B/09 indicated Patient #1 culty in transfer, poor all and difficulty with gait."  B/09 indicated Patient #1 culty in transfer, poor all and difficulty with gait."  B/09 indicated Patient #1 culty in transfer, poor all and difficulty with gait."  B/09 indicated Patient #1 culty in transfer, poor all and difficulty with gait."	G 144				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
	297126	B. WING	3		05/0	06/2009
NAME OF PROVIDER OR SUPPLIER  STELLAR HEALTH SYSTEM INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2940 S JONES BLVD STE A LAS VEGAS, NV 89146			
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
indicated Patient #3 in therapy (OT) and soci the form titled "Recom"problems with telep form lacked documen disciplines were notificated non-working telephon the form was the RN's Patient #8  Patient #8  Patient #8 was admitted diagnoses including of extremity, abnormality of chronic obstructive anemia.  The clinical record for Conference (CC) note 12/23/08 and 2/18/09 the signature of one of 9/1/08 had no signature documented evidence of the "patient and spot Patient #12  Patient #12  Patient #12 was admited diagnoses including lacked documented note lacked note lacked documented note lacked note l	eeded PT, occupational ial services. In the area of immendation," the RN wrote, ohone not working" The tation indicating the other ed regarding the e. The only signature on s.  ed on 8/27/08, with open wound to the lower of gait, acute exacerbation bronchitis and pernicious  Patient #8 contained Case es dated 8/27/08, 9/1/08, Three of the CC notes had discipline. The note dated endicating PT was notified ouse requesting PT."  tted on 1/7/09 with umbago, difficulty walking, betes mellitus.  Patient #12 contained a CC disigned by a RN, indicating to require PT services. The	G ~	144			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	297126	B. WING		05/6	06/2009
NAME OF PROVIDER OR SUPPLIER  STELLAR HEALTH SYSTEM INC		29	EET ADDRESS, CITY, STATE, ZIP CODI 940 S JONES BLVD STE A AS VEGAS, NV 89146	•	
PREFIX (EACH DEFICIENCY MU	IENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 144 Continued From page 6 note lacked the signature Patient #15  Patient #15 was admitted diagnoses including diabout muscle weakness and streevacuation of subdural here. The clinical record for Pac CC form dated 4/13/09, was transported to an acclinical record lacked a CC change in the patient's conclinical record lacked a CC change in the patient's conclinical record lacked a CC change in the patient's conclinical record lacked a CC change in the patient's conclinical record lacked a CC change in the patient's conclinical record lacked a CC change in the patient's condition.  On 5/1/09 at 9:20 AM, the Services (DPS) indicated held at the start of care (aday after the start of care and any time a patient excondition.  On 5/1/09 at 9:25 AM, the that a "case conference" person did not make a case conference in the knee and abdomer disease including skin of the knee and abdomer disease and hypertension Documentation in Patient regarding case conference form and the conference form	I on 4/13/09 with etes mellitus, debility, atus post craniotomy for ematoma.  Itient #15 contained one On 4/20/09, the patient ate care facility. The C form indicating a pondition.  E Director of Professional case conferences were and to be submitted the end to be submi	G 144			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		297126	B. WIN	IG_		05/0	6/2009
	ROVIDER OR SUPPLIER HEALTH SYSTEM INC		'	2	REET ADDRESS, CITY, STATE, ZIP CODE 2940 S JONES BLVD STE A LAS VEGAS, NV 89146	1 00.0	5/ <b>2</b> 000
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
G 144	individuals). There we no recommendations  - Discipline Referral S by one individual. The entered, including Pathered, includi	cheer no services checked and indicated.  Sheet dated 3/25/09 signed ere was no information tient #13's name.  Form undated in the medical individuals (unable to sof the individuals). There intered including Patient  Sheet, undated, in the ewas signed by Employee #4 all (unable to identify). There intered, including Patient  For the dated 11/29/08 indicated Nursing). There was no inchecked on the form ere form was signed by the other people (unable to is).  For the dated 9/29/08 indicated N & PT (Physical Therapy).	G	144			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	297126	B. WING		05/0	6/2009	
NAME OF PROVIDER OR SUPPLIER STELLAR HEALTH SYSTEM II	NC	2	REET ADDRESS, CITY, STATE, ZIP CODE 2940 S JONES BLVD STE A LAS VEGAS, NV 89146			
PREFIX (EACH DEFIC			ID PROVIDER'S PLAN OF CORE PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE AI DEFICIENCY)		(X5) COMPLETION DATE	
undated, revealed held regularly to review the plan or of continued serv documented separecord and should time of admission discharge"  On 5/5/09 in the aprofessional Serv provide additional Conferences of Page Conference and sometimes the medical record."  484.14(g) COOR SERVICES  A written summant to the attending page This STANDARD Based on intervied document review written summary physician at least patients (#1, 8, 12). Findings include:  Patient #1  Patient #1 was addiagnoses including joint pain, cardiado	page 8  y titled Case Conference, d: "Case conferences shall be eview problem cases and to f treatment for appropriateness ices. Such conferences shall be arately and or in the clinical d be held on each client at the f, monthly and prior to  afternoon, the Director of rices (DPS) was unable to I information regarding the Case atient #13. The DPS explained, as are usually done by telephone the paperwork doesn't get into the DINATION OF PATIENT  Ty report for each patient is sent hysician at least every 60 days.  is not met as evidenced by: w, clinical record review and the agency failed to ensure a report was sent to the attending every 60 days for 8 of 15 2, 6, 7, 10, 13, 14).	G 144				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER		,	2	REET ADDRESS, CITY, STATE, ZIP CODE 2940 S JONES BLVD STE A LAS VEGAS, NV 89146	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE A DEFICIENCY)		.D BE	(X5) COMPLETION DATE
G 145	Continued From page	9	G	145			
	"Clinical Summary" (I Treatment) for each of ending 12/27/08 and evidence of the patient of each period, treatment's progress (or patient's overall status certification period.  Patient #8  Patient #8 was admit diagnoses including of extremity, abnormality of chronic obstructive anemia.  The clinical record for "Clinical Summary" (I Treatment) for each of ending 10/25/08, 12/2 The reports lacked extratus at the beginning provided and the patithereof) as well as the the end of each certification and diagnoses including I hypertension and diagnoses including I hypertension and diagnoses Summary" (I	ted on 8/27/08 with open wound to the lower by of gait, acute exacerbation bronchitis and pernicious ar Patient #8 contained a past page of the Plan of of the certification periods 24/08, 2/22/09 and 4/23/09. Vidence of the patient's ag of each period, treatments pent's progress (or lack patient's overall status at ication period.					
	ending 3/7/09 and 5/6	6/09. The reports lacked					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		297126	B. WIN	G		05/0	6/2009
	ROVIDER OR SUPPLIER		•	294	ET ADDRESS, CITY, STATE, ZIP CODE 10 S JONES BLVD STE A S VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
G 145	of each period, treating patient's progress (or patient's progress (or patient's overall status).  On 5/5/09 in the more clinicians were supponew form created in helinicians for the detaincluding problems at status.  Patient #6  Patient#6 was admitted diagnoses including wongestive heart failuance of care sent to the three was no documed and current status of the certification and current status of the	nt's status at the beginning ments provided and the lack thereof) as well as the s at the end of each ning, the DPS indicated the seed to have started using a mouse to prompt the ils of the certification period, a start of care and current start of care and current ed on 1/14/09 with weakness, debility, are and hypertension.  The essed on 3/14/09 and a new me physician for signature, ented evidence that a 60 was sent to the physician atus of the patient at the on period, patient progress,	G	145			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		297126	B. WIN	G		05/0	6/2009
	OVIDER OR SUPPLIER		•	294	EET ADDRESS, CITY, STATE, ZIP CODE 40 S JONES BLVD STE A AS VEGAS, NV 89146	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	I	ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTIO TAG CROSS-REFERENCED TO THI DEFICIENCY)		LD BE	(X5) COMPLETION DATE
G 145	pulmonary disease, as Patient #10 was reas new plan of care sent signature. There was that a 60 day summa physician which inclu at the start of the cert progress, and current Patient #13  Patient #13 was adm diagnoses including sof the knee and abdo disease, and hyperte  There was no docum day summary report of Patient #13 at the star patient progress, and was sent to the physic certification periods.  Patient #14  Patient #14  Patient #14 was adm diagnoses including rehypertension and depressed to the physical patient #14.	itted on 1/28/09 with diabetes, chronic obstructive and hypertension.  sessed on 3/28/09 and a set to the physician for no documented evidence and the status of the patient diffication period, patient status of the patient.  sitted on 6/9/07 with skin disorder, open wounds men, peripheral vascular ansion.  ented evidence that a 60 which included the status of the patient, current status of the patient, cian for the last two sitted on 10/10/08 with muscle weakness, pressive disorder.	G	145			
	day summary report v	ented evidence that a 60 which included the status of rt of the certification period,					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		297126	B. WIN	3 <u></u>		05/0	6/2009
	OVIDER OR SUPPLIER		·	29	EET ADDRESS, CITY, STATE, ZIP CODE 140 S JONES BLVD STE A AS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
G 145 G 158	was sent to the physic certification periods. 484.18 ACCEPTANC	current status of the patient,		145			
		plan of care established wed by a doctor of medicine, ric medicine.					
	Based on interview a	not met as evidenced by: nd clinical record review, the re the written plan of care 15 patients (#3, 8).					
	Patient #3						
	Patient #3 was admitt diagnoses including o difficulty walking, peri obesity.						
	(one page) dated 4/8/ therapist (PT) wrote, Left voice messages machine (702) (phone attempts on 3/27/09,	/Physician Orders (CN/PO) /09, on which the physical 'Pt (patient) is a 'no pick-up'. to pt's phone answering					
	indicating Patient #3's	cked documented evidence s physician was notified the seen by PT as of 4/8/09.					
		noon, the DPS explained, having telephone problems pastthere is barely					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SUF COMPLETI	
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	COVIDER OR SUPPLIER  HEALTH SYSTEM INC	237120	<u> </u>	29	EET ADDRESS, CITY, STATE, ZIP CODE 940 S JONES BLVD STE A AS VEGAS, NV 89146	05/00	6/2009
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
G 158	move around in."  Patient #8  Patient #8 was admitt diagnoses including of extremity, abnormality of chronic obstructive anemia.  The physician's order recertification period of indicated the skilled monce a week for one of two weeks and once a were two days left in certification period. The documented evidence either of those two day documentation indicated that no visit were ason why.  484.18(b) PERIODIC CARE  Agency professional sphysician to any charalter the plan of care.  This STANDARD is a Based on clinical receits of the surface of	ted on 8/27/08 with open wound to the lower y of gait, acute exacerbation bronchitis and pernicious of 12/26/08 through 2/22/09 oursing (SN) frequency was week; two times a week for a week for six weeks. There the first week of the new of the clinical record lacked as a SN visit was made on anys. There was no thing the physician was would be made and the record lacked and the record lacked end as the service of the physician was would be made and the record lacked and the record		158			
	Based on clinical reco to ensure staff promp any changes that sug plan of care for of	ord review, the agency failed tly alerted the physician to gested a need to alter the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE  A. BUILDING	CONSTRUCTION	(X3) DATE S COMPLI	
		297126	B. WING		05	/06/2009
	ROVIDER OR SUPPLIER		2940	T ADDRESS, CITY, STATE, ZIP CO S JONES BLVD STE A VEGAS, NV 89146	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO ' DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
G 164	difficulty walking, per obesity.  A Communication No page) dated 4/8/09, a therapist (PT) revealed 484.18(c) CONFORM ORDERS  Drugs and treatments agency staff only as of the standard or interview and agency failed to ensure administered or for 3 of 15 patients (#Findings include:  Patient #3  Patient #3 was admit diagnoses including of difficulty walking, per obesity.  Patient #3's clinical reprofile (MP), dated 3, listed on the MP was	ted on 3/23/09 with deep vein thrombosis, ipheral vascular disease and of the Physician Order (all one and written by the physical ed, MANCE WITH PHYSICIAN are administered by ordered by the physician.  The all drugs and treatments and are administered by a physician etc. (a), and the are all drugs and treatments and are ordered by a physician etc. (b), and the are all drugs and treatments and are ordered by a physician etc. (c), and the are all drugs and treatments and are ordered by a physician etc. (c), and the are all drugs and treatments and are ordered by a physician etc. (c), and the are all drugs and treatments and are ordered by a physician etc. (c). (d) are ordered by a physician etc. (d) are or	G 164			
	every day.  Patient #3's clinical re	rams to be taken by mouth ecord contained:				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		297126	B. WIN	IG		05/0	6/2009
	OVIDER OR SUPPLIER			29	EET ADDRESS, CITY, STATE, ZIP CODE 940 S JONES BLVD STE A AS VEGAS, NV 89146	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 165	Continued From page	e 15	G	165			
	signed by the Directo (DPS) which read, "L orders received Dr. (I hold Coumadin until I a physician order, cand signed by the DF Coumadin 10 milligra and dosage instructio a physician order, cand signed by the DF Coumadin 8 milligram weekly lab draw."  Patient #3's MP lacked changes made regard On 5/5/09 in the more	dated 4/11/09 at 2:00 PM PS which read, "Hold ms daily until next lab draw in from MD."  dated 4/17/09 at 12:00 PM PS which read, "Begin ns daily in pm and continue  ed documented evidence of ding the Coumadin doses.  ning, the DPS indicated, the copy of the MP in (all) the s whenever there is a s (including doses)."					
	diagnoses including of extremity, abnormality	open wound to the lower by of gait, acute exacerbation bronchitis and pernicious					
	nursing (SN) was to " patient/caregiver rega (cleanse) with saline, gauze, cover with 2X	Patient #8 indicated skilled perform and teach arding wound care: Cleance pat dry with 2X2 sterile 2, secure with tape, dressing aily initially, then 2 - 3Xwk."					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		297126	B. WIN	IG		05/0	6/2009
	ROVIDER OR SUPPLIER		•	29	EET ADDRESS, CITY, STATE, ZIP CODE 040 S JONES BLVD STE A AS VEGAS, NV 89146	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 165	Continued From page	e 16	G	165			
	dated 8/28/08, 8/29/0 the SN documented, NSS (normal saline s Covered area c Xero dressing) and secure to keep area clean ar On Patient #8's NCN documented, "clea dry. Applied Hydroge with Kerlix and secure to keep area clean ar On Patient #8's NCN 9/24/08, 9/26/08, 9/26 10/6/08, 10/08/08, 10 the SN documented ' pat dry. Applied wou Xeroform, DSD, wrap tape. SN reminded p dry."	form, DSD (dry sterile d c tape instructed patient and dry."  dated 9/5/08, the SN aned area c NSS and pat el, covered c DSD, wrapped ed c tapeinstructed patient and dry. "  s dated 9/7/08, 9/22/08, 9/08, 10/1/08, 10/13/08, 10/15					
	SN documented "cl dry. Applied Hydroge with telfa, wrapped c	dated 9/10/08, 9/15/08, the eaned area c NSS and pat el to wound area. Covered Kerlix and secured c tape eep area clean and dry."					
	the SN documented ' and pat dry. Applied Xeroform telfa wrapp	dated 9/17/08 and 9/19/08,  /cleaned area with NSS hydrogel, covered c ed c Kerlix and secured c ot (patient) to keep area					
		dated 10/17/08, the SN lied wound care solution					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SUF COMPLET	
		297126	B. WIN	G		05/0	6/2009
	ROVIDER OR SUPPLIER HEALTH SYSTEM INC		'	29	EET ADDRESS, CITY, STATE, ZIP CODE 40 S JONES BLVD STE A AS VEGAS, NV 89146	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 165	given by Dr. Then come wrapped c some kerlinstructed pt to keep of the common of the c	wered c Xeroform, DSD, x and secured c tape. SN area clean and dry."  dated 10/20/08, the SN ned area c NSS and pat dry. nk kept area uncovered. s any changes to notify MD."  dated 1/6/09, the SN cussion made on upper & loosen mucous"  care did not include orders performed. There was no ne clinical record for by the home health nurse.  ecord contained 17 NCNs was on 2 liters of oxygen per  catient #8 was on 4 liters of	G	165			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		297126	B. WIN		·	05/0	0/0000
NAME OF PR	OVIDER OR SUPPLIER	23/120			EET ADDRESS, CITY, STATE, ZIP CODE	1 05/0	6/2009
STELLAR	HEALTH SYSTEM INC				AS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
G 165	Continued From page minute continuously v		G	165			
	Patient #12 was adm diagnoses including I hypertension and dia The registered nurse 1/7/09 and referred p	umbago, difficulty walking,					
G 166	On 3/6/09, the RN mare recertify Patient #12 for the see Patient #12 for the recertification visit do On 5/1/09 in the after Professional Services nurse who was seein document accurately paperwork according manner. 484.18(c) CONFORM ORDERS  Verbal orders are put dated with the date or nurse or qualified the	cked an order for the RN to be assessment and ne on 3/6/09.  Innoon, the Director of s (DPS) revealed that the g Patient #8 did not and did not submit her to the schedule/in a timely  MANCE WITH PHYSICIAN  In writing and signed and f receipt by the registered rapist (as defined in section responsible for furnishing or	G	166			
		not met as evidenced by: clinical record review and					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATE SUF	
			A. BUI		<u> </u>		
		297126	B. WIN	IG		05/0	6/2009
	OVIDER OR SUPPLIER HEALTH SYSTEM INC			2	REET ADDRESS, CITY, STATE, ZIP CODE 1940 S JONES BLVD STE A LAS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
G 166	physicians' orders we within 30 days for 2 or Findings include:  Patient #1  Patient #1 was admitt diagnoses including rejoint pain, cardiac dyssecondary to chronic  Patient #1's clinical reorder, dated 2/3/09, fiprn (as needed) visit. The 2/3/09 order for a signed by the ordering the afternoon.  Patient #3  Patient #3  Patient #3  Patient #3  Patient #3 was admitt diagnoses including of difficulty walking, periobesity.  The Plan of Treatment signed by the ordering the afternoon.  The agency's Policy and Plan of Care/Orders 30	e agency failed to ensure ere signed by the physician of 15 patients (#1, 3).  Ited on 6/30/08, with muscle weakness, multiple enhythmia and anemia kidney disease.  Record contained a physician's or a skilled nurse to make a for a lab draw.  Ited on 3/23/09 with gephysician as of 5/1/09 in  Ited on 3/23/09 with deep vein thrombosis, inheral vascular disease and int dated 3/23/09, was not g physician as of 5/5/09 in  Ited on 3/23/09 with deep vein thrombosis, inheral vascular disease and int dated 3/23/09, was not g physician as of 5/5/09 in  Ited on 3/23/09 with deep vein thrombosis, inheral vascular disease and int dated 3/23/09, was not g physician as of 5/5/09 in  Ited on 3/23/09 with deep vein thrombosis, inheral vascular disease and int dated 3/23/09, was not g physician as of 5/5/09 in  Ited on 3/23/09 with deep vein thrombosis, inheral vascular disease and int dated 3/23/09, was not g physician as of 5/5/09 in  Ited on 3/23/09 with deep vein thrombosis, inheral vascular disease and int dated 3/23/09, was not g physician as of 5/5/09 in  Ited on 3/23/09 with deep vein thrombosis, inheral vascular disease and int dated 3/23/09, was not g physician as of 5/5/09 in  Ited on 3/23/09 with deep vein thrombosis, inheral vascular disease and int dated 3/23/09, was not g physician as of 5/5/09 in	G	166	<u>'</u>		
G 172	order" 484.30(a) DUTIES O		G	172			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION  G	(X3) DATE SUF	
		297126	B. WIN	IG		05/0	6/2009
	OVIDER OR SUPPLIER			2	REET ADDRESS, CITY, STATE, ZIP CODE 2940 S JONES BLVD STE A LAS VEGAS, NV 89146	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
G 172	This STANDARD is a Based on clinical reconfacility failed to ensur regularly re-evaluated 15 patients (#12, 15). Findings include:  Patient #12  Patient #12 was adm diagnoses including I hypertension and dia  During the initial asser registered nurse (RN trace edema in both form the physical therapis visit notes that Patien in both feet. The note indicating the PT had the patient's physicial edema.  Regarding a 4/8/09 vithe registered nurse (have her take her sho	regularly re-evaluates the dis.  not met as evidenced by: ord review and interview, the ethe registered nurse dithe nursing needs for 2 of dithe nursing needs for distinct the nursing needs for 2 of distinct the nursing needs for 2 o	G	172			
		cked documented evidence Patient #12's nursing needs					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		297126	B. WIN	G		05/0	6/2009
	OVIDER OR SUPPLIER		•	29	EET ADDRESS, CITY, STATE, ZIP CODE 040 S JONES BLVD STE A AS VEGAS, NV 89146	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 172	muscle weakness an evacuation of subdur.  The registered nurse evaluation and prepa Patient #15. The lice patient two consecutivisit.  On 4/15/09, Patient # increased sleepiness a communication not patient's family reschevaluation visit from 4 to the patient's increased.  On 5/6/09 at 4:10 PM new to home health a everything I should be do"  On 5/6/09 at 4:20 PM indicated the patient bed" on 4/18/09. The called the agency on remember who she some caregiver indicated the patient to the clinical record later indicating the RN materials.	in the patient's feet.  itted on 4/13/09 with diabetes mellitus, debility, d status post craniotomy for all hematoma.  (RN) performed the initial red the plan of care for nsed practical nurse saw the ve times after the RN's initial and lethargy. According to an in the clinical record, the eduled a physical therapy 4/15/09 to 4/17/09 secondary sed sleepiness and lethargy.  I, the RN indicated she was and "I don't feel like I'm doing at I don't really know what to the caregiver indicated she 4/20/09 to tell them (didn't poke with) about the fall. ed no one came out to	G	172			
	<del>4</del> /∠U/U∂.						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION  G	(X3) DATE SUR COMPLETE	
		297126	B. WIN	IG		05/06	6/2009
	OVIDER OR SUPPLIER			2	REET ADDRESS, CITY, STATE, ZIP CODE 2940 S JONES BLVD STE A LAS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
G 173	484.30(a) DUTIES O NURSE	F THE REGISTERED	G	173			
	The registered nurse necessary revisions.	initiates the plan of care and					
	Based on record revieus failed to ensure an ac	not met as evidenced by: ew and interview, the facility ccurate and complete plan of and revised as necessary #13, 12, 15).					
	Patient #13						
	with diagnoses includ	itted to the agency on 6/9/07 ling skin disorders, open ad abdomen, peripheral hypertension.					
	This was signed by th	Nursing) frequency: (blank). ne RN (Registered Nurse) ere was no date next to the					
	1/30/09 at 04:30 PM, "Clarification of visits T/C (telephone call) to (skilled visits) were m signature. She will fax Nurse) 1 Wk 9 (once signed POT (Plan of	s (DPS) obtained a t titled Patient Notes dated which revealed: by sn (Skilled Nurse): o MD to inform that SV issed when sent for x us her order for SN (Skilled a week for 9 weeks) per					
		cian order for Patient #13					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION  G	(X3) DATE SUF COMPLETI	
		297126	B. WIN	1G _		05/0	6/2009
	OVIDER OR SUPPLIER			:	REET ADDRESS, CITY, STATE, ZIP CODE 2940 S JONES BLVD STE A LAS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
G 173	Continued From page	e 23	G	173	3		
	Patient #12						
	Patient #12 was adm diagnoses including lu hypertension and dial	umbago, difficulty walking,					
		essment on 1/7/09, the ) noted Patient #12 had leet.					
		t (PT) documented in eight t #12 had increased edema					
	indicating the RN re-	cked documented evidence evaluated the patient's status o Patient #12's plan of care in the patient's feet.					
	Patient #15						
		liabetes mellitus, debility, d status post craniotomy for					
	evaluation and prepa Patient #15. The lice	(RN) performed the initial red the plan of care for nsed practical nurse saw the ve times after the RN's initial					
	caregiver re-schedule (from 4/15/09 to 4/17/	and lethargy. The patient's ed a physical therapy visit					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		297126	B. WING		05/	06/2009	
	ROVIDER OR SUPPLIER		294	T ADDRESS, CITY, STATE, ZIP CODE O S JONES BLVD STE A S VEGAS, NV 89146	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
G 178	new to home health a everything I should be do"  On 5/6/09 at 4:20 PM indicated the patient bed" on 4/18/09. The called the agency on remember who she so the caregiver indicate evaluate the patient to the clinical record law indicating the RN resemble changes to the Patient #15's nursing 4/20/09. 484.30(a) DUTIES ONURSE  The registered nurse programs, and supernursing personnel.  This STANDARD is a Based on record revice nurse the licensed programs and supernursing personnel.  This STANDARD is a Based on record revice nurse the licensed programs and supernursing personnel.  This STANDARD is a Based on record revice nurse the licensed programs and supernursing personnel.  This STANDARD is a Based on record revice nurse the licensed programs include:  Patient #1 was admitted in the supernursing include:  Patient #1 was admitted in the supernursing including inclu	I, the RN indicated she was and "I don't feel like I'm doing at I don't really know what to I, Patient #15's caregiver I'had a relapse and fell out of e caregiver indicated she 4/20/09 to tell them (didn't poke with) about the fall. ed no one came out to hat day.  Cked documented evidence evaluated the patient and plan of care addressing needs on 4/15/09 and  F THE REGISTERED  participates in in-service vises and teaches other  not met as evidenced by: ew, the facility failed to practical nurse (LPN) was gistered nurse every 30 days 11, 8).	G 178				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		297126	B. WING _		05/0	6/2009
	OVIDER OR SUPPLIER		Sī	TREET ADDRESS, CITY, STATE, ZIP CODE 2940 S JONES BLVD STE A LAS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
G 178	practical nurse (LPN) times (from 2/23/09 the record lacked docume supervisory visit by the during the nine week.  Patient #8  Patient #8 was admitted diagnoses including dextremity, abnormality of chronic obstructive anemia.  After the RN admitted the patient 25 consecutive under the patient 25	kidney disease.  d Patient #1, the licensed saw Patient #1 thirteen brough 4/20/09). The clinical ented evidence of a me registered nurse (RN) time frame.	G 17	8		
G 182	recertification assess LPN then saw the par consecutive weeks.  The clinical record lad of a supervisory by the 11/28/08. 484.30(b) DUTIES OF PRACTICAL NURSE.  The licensed practical and materials for treat technique as required.  This STANDARD is in	ment and paperwork. The tient once a week for six  cked documented evidence to RN from 8/28/08 through  F THE LICENSED  Il nurse prepares equipment themts, observing aseptic	G 18	2		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		297126	B. WIN	G		05/0	6/2009
	ROVIDER OR SUPPLIER HEALTH SYSTEM INC		•	29	EET ADDRESS, CITY, STATE, ZIP CODE 940 S JONES BLVD STE A AS VEGAS, NV 89146	, 300	<u></u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODER (DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
G 182	observe proper technical patient for 1 of 15 patient for 1 of 15 patient #2  The start of care for Fidiagnoses were chrodiabetes.  On 5/1/09 in the after of pain between her to Employee #5 examin pen. Employee #5 se with the tip of her per After examining the realeft foot with the pen, proceeded document pen without cleaning 484.32 THERAPY SE	ique when assessing a ients (#2).  Patient #2 was 2/28/09. The nic pain, hypertension, and  noon, Patient #2 complained oes on her right foot. ed the patient's foot with her parated the resident's toes and did not don any gloves. sident's toes on the right and Employee #5 then the results using the same the tip.  ERVICES		182			
	This STANDARD is Based on clinical received to ensure the physical registered nurse and change in the condition Findings include:  Patient #12  Patient #12 was adm	not met as evidenced by: ord review, the agency failed all therapist notified the physician when there was a on for 1 of 15 patients (#12).  itted on 1/7/09 with umbago, difficulty walking,					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		297126	B. WIN	IG		05/0	6/2009
	OVIDER OR SUPPLIER		· ·	2	REET ADDRESS, CITY, STATE, ZIP CODE 940 S JONES BLVD STE A AS VEGAS, NV 89146	33.3	<i>3.</i> 2000
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETION DATE
G 188	Continued From page	e 27	G	188			
		essment on 1/7/09, the ) noted Patient #12 had feet.					
G 223	visit notes that Patien in both feet. The note indicating the PT had the patient's physiciar edema. The notes la	was instructed on measures . IMENT & DUTIES OF	G	223			
	-	e is assigned to a specific					
	Based on record revie	not met as evidenced by: ew and interview, the agency dome Health Aide Plan of accurately for 1 of 15					
	Patient #11						
	Patient #11 was admi diagnoses including n and fatigue, COPD (C Pulmonary Disease) a	muscle weakness, malaise Chronic Obstructive					
G 224	which was in the med or dated.		G	224			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		297126	B. WIN	G		05/0	6/2009
	OVIDER OR SUPPLIER  HEALTH SYSTEM INC			29	EET ADDRESS, CITY, STATE, ZIP CODE 940 S JONES BLVD STE A AS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
G 224	health aide must be purese or other appropressible for the substantial health aide under particular this STANDARD is a Based on interview at facility failed to ensure	nstructions for the home orepared by the registered oriate professional who is upervision of the home ragraph (d) of this section.  Inot met as evidenced by: Ind clinical record review, the e written instructions for the complete for of 15	G	224			
	Findings include:						
	ensure the Home Hea	ew, the agency failed to alth Aide Plan of Care was for 1 of 15 patients (#11).					
	and fatigue, COPD (C Pulmonary Disease) a Patient #11's Home F	nuscle weakness, malaise Chronic Obstructive					
G 226	provision of hands on of simple procedures	health aide include the personal care, performance as an extension of therapy assistance in ambulation or	G	226			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		IPLE CONSTRUCTION  IG	(X3) DATE SUF	
		297126	B. WIN	1G _		05/0	6/2009
	OVIDER OR SUPPLIER		<b>,</b>	:	REET ADDRESS, CITY, STATE, ZIP CODE 2940 S JONES BLVD STE A LAS VEGAS, NV 89146	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
G 226		e 29 ordinarily self administered.	G	226	6		
	Based on interview ar failed to properly docu	not met as evidenced by: nd record review, the agency ument hands on personal or 2 of 15 patients (#4, 15).					
	Findings include:						
	Patient #4						
	diagnoses were diffic	Patient #4 was 9/26/08. The ulty in walking, muscle sorder, and pain in limb.					
	and signed by the pat 1/23/09, and 1/21/09	ealth Aide Visit Note's dated cient on 1/29/09, 1/26/09, had all the sections left care documented on the					
	•	noon, the Director of Home Health Aide Visit d out and the blank forms					
	Patient #15						
		liabetes mellitus, debility, d status post craniotomy for					
	#15 (prepared by the	e Plan of Care for Patient registered nurse) indicated (HHA) was to check vital					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SU COMPLET	
		297126	B. WING		05/0	06/2009
	OVIDER OR SUPPLIER		2	REET ADDRESS, CITY, STATE, ZIP CODE 940 S JONES BLVD STE A .AS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 226	shower 2 - 3 times per perform hair care ond week; 4) apply lotion clean/file fingernails of catheter care every vand transfers to chair for feeding as needed every week.  The clinical record for Home Health Aide Vis 4/15/09 and 4/17/09).  The 4/15/09 HHAVN indicating the HHA gabath that day.  The 4/17/09 HHAVN indicating the HHA gabath that day.  The 4/17/09 HHAVN indicating the HHA per patient #15.  There was no docum weighed Patient #15 fingernails on 4/15/09  On 5/19/09 at 9:50 Al patient's daughter had a shower (with chair in catheter care prior to and 4/17/09. The HH vital signs and applied the HHA indicated the	weigh once a week and 1) or week; 2) shampoo and the a week; 3) shave once a to the skin every visit; 5) once a week; 6) perform disit; 7) assist with ambulation divided as needed; 8) set up diright; and 9) change bed linens or Patient #15 contained two disit Notes (HHAVN) (dated  Contained documentation dive Patient #15 a tub/shower  Contained documentation dive Patient #15 a tub/shower	G 226			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION  G	(X3) DATE SUF COMPLETI	
		297126	B. WIN	IG _		05/0	6/2009
	OVIDER OR SUPPLIER		•	2	REET ADDRESS, CITY, STATE, ZIP CODE 2940 S JONES BLVD STE A LAS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE	
G 229	484.36(d)(2) SUPER'	VISION	G	229			
	described in paragrap	(or another professional oh (d)(1) of this section) e visit to the patient's home on every 2 weeks.					
	Based on record review, the agency fa	re performed by a registered					
	Patient #11						
	Patient #11 was adm diagnoses including r and fatigue, COPD (0 Pulmonary Disease)	nuscle weakness, malaise Chronic Obstructive					
	Patient #11's Plan of indicated:	Care dated 3/16/09					
	week for 4 weeks), 1	sing Assistant): 2W4 (twice a W5 (once a week for 5 personal hygiene, ADL's ring) and light					
	Patient #11 on the fol	cated visits were done for llowing dates: 3/19/09, 6/09, 3/31/09, 4/5/09, 4/7/09,					
	indicated the RN (Re visit was completed o	tient #11's medical record egistered Nurse) supervisory on 4/15/09. There was no e that a supervisory visit was					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION  G	(X3) DATE SUF COMPLET	
		297126	B. WIN	IG_		05/0	6/2009
	OVIDER OR SUPPLIER		•	2	REET ADDRESS, CITY, STATE, ZIP CODE 2940 S JONES BLVD STE A LAS VEGAS, NV 89146	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DRRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE	
G 229	Supervision, undated -"Supervisory visits si Registered Nurse eve in the clinical record."  On 5/6/09 in the after Professional Services were no additional Ri completed for Patient  Patient #4  The start of care for F diagnoses were diffic weakness, seizure di The last home health for Patient #4 was co HHA continued to pro until 4/23/09.	ed Home Health Aide , revealed: hall be made by the ery 14 days and documented moon, the Director of s (DPS) confirmed that there N supervisory visits	G	229			
G 236	Nursing could not pro	duce HHA supervisory visit ned for Patient #4 between	G	236			
	A clinical record contacurrent findings in according professional standard patient receiving homaddition to the plan of appropriate identifying physician; drug, dieta	aining pertinent past and cordance with accepted is maintained for every					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		297126	B. WIN	IG		05/0	6/2009
	OVIDER OR SUPPLIER  HEALTH SYSTEM INC		·	2	REET ADDRESS, CITY, STATE, ZIP CODE 1940 S JONES BLVD STE A LAS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
G 236	-	e 33 mary reports sent to the and a discharge summary.	G	236			
	Based on clinical reco	not met as evidenced by: ord review, the facility failed ast findings were obtained 3, 7, 8, 10, 12, 14).					
	Findings include:						
G 337	and 14 lacked docum	or Patients #3, 7, 8, 10, 12 sented evidence of history her pertinent past medical GIMEN REVIEW	G	337			
	review of all medication using in order to identered effects and drug react drug therapy, significations.	assessment must include a ons the patient is currently tify any potential adverse tions, including ineffective ant side effects, significant blicate drug therapy, and drug therapy.					
	Based on observation facility failed to maintain	not met as evidenced by: n and record review, the ain an up to date review of r 2 of 15 patients (#4, 3).					
	Findings include:						
	Patient #4						
	diagnoses were diffic	Patient #4 was 9/26/08. The ulty in walking, muscle sorder, and pain in limb.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION  G	COMPLET	
		297126	B. WIN	IG_		05/0	6/2009
	OVIDER OR SUPPLIER			2	REET ADDRESS, CITY, STATE, ZIP CODE 2940 S JONES BLVD STE A LAS VEGAS, NV 89146	1 00/0	0/2003
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 337	A home visit was perfafternoon. Inside pat undated medication performedications. The state each medication was Patient #4's clinical rerevealed an updated dated 3/21/09 with se start date and the cla	formed on 4/30/09 in the sient #4's home folder was an profile form which listed 15 rt date and the class for not entered on the form.  Ecords (at the office) medication profile form ven medications listed. The sist for each medication was rm. The form was not found	G	337			
	obesity.  Patient #3's clinical re a physician order, or signed by the Directo (DPS) which read, "Lo	leep vein thrombosis, pheral vascular disease and ecord contained: dated 4/3/09 at 3:00 PM and r of Professional Services ab results received and					
	hold Coumadin until I  a physician order, or and signed by the DF Coumadin 10 milligra and dosage instructio  a physician order, or and signed by the DF	dated 4/11/09 at 2:00 PM 'S which read, " Hold ms daily until next lab draw					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		297126	B. WING		05/0	6/2009
	ROVIDER OR SUPPLIER HEALTH SYSTEM INC		2	REET ADDRESS, CITY, STATE, ZIP CODE 2940 S JONES BLVD STE A LAS VEGAS, NV 89146	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 337	clinical record lacked changes made regard On 5/5/09 in the more "The nurses update t patients' home folder change in medication On 5/5/09 in the more nurses were suppose MP in Patient #3's home folders.	e (MP) in Patient #3's documented evidence of ding the Coumadin doses.  ning, the DPS indicated, he copy of the MP in (all) the s whenever there is a	G 337	,		